MSP

MEDICARE SECONDARY PAYER

INFORMATION FOR EMPLOYERS

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This booklet is meant to explain the MSP requirements but is not a legal document. The official Federal requirements are contained in the relevant laws, regulations and Rulings.

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MEDICARE SECONDARY PAYER

A MESSAGE FROM THE ADMINISTRATOR

Medicare is a Federal health insurance program for people 65 or over, for certain disabled people, and for most people with permanent kidney failure.

Some people who can get Medicare also have coverage under a group health plan. Employers who sponsor or contribute to health benefit plans for their employees and employees' families need to know which health plan pays first for people with Medicare–Medicare or the group health plan. Sometimes Medicare pays second.

As a sponsor of, or contributor to, group health plans that cover people who may have Medicare, you need to know when Medicare is secondary payer to your health plan. This booklet explains the Medicare secondary payer (MSP) law and what you need to do to comply with MSP requirements.

This booklet also explains an information collection procedure required by Federal law. Under the law, the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), and the Internal Revenue Service (IRS) match information from their records to determine likely cases in which Medicare should be secondary payer to another insurer. HCFA then contacts employers to confirm whether employees and their families who have Medicare also have group health coverage under an employer plan. This booklet explains what you are required to do when you are contacted.

Assuring that the Medicare secondary payer rules are followed will enable your plan to process claims correctly. This in turn will prevent administrative difficulties and lost time and money from mistaken payments and recovery actions by Medicare.

We appreciate your cooperation and hope you find this booklet useful.

Bruce C. Vladeck
Administrator
Health Care Financing Administration

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GROUP HEALTH PLANS AND THE MEDICARE SECONDARY PAYER PROVISIONS

Some people who have Medicare also have group health plan coverage. Usually, Medicare is their primary payer, which means that Medicare pays first on their health care claims. Sometimes, the other plan must pay first. In that case, Medicare is the secondary payer.

Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans benefits. Since 1980, new laws have made Medicare the secondary payer for several additional categories of people. The section titled "Whom Does MSP Affect?" describes those additional categories of people.

Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "coordination of benefits" when assigning responsibility for first and second payment.)

The terms "Medicare supplement" and "Medicare secondary payer" are sometimes confused. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for the expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program. **An employer cannot offer, subsidize or arrange for a Medicare supplement policy where the law makes Medicare the secondary payer.**

Federal law takes precedence over conflicting State law and private contracts. Thus, for the categories of people described in this booklet, Medicare is secondary payer regardless of State law or plan provisions. These Federal requirements are found in Section 1862(b) of the Social Security Act (42 U.S.C. Section 1395y(b)). Applicable regulations are found at 42 C.F.R. Part 411. You should verify that your group health plan is in conformity with Federal requirements and you should notify employees of their rights and responsibilities in any benefit brochures you give them.

WHOM DOES MSP AFFECT?

Medicare is secondary payer to some group health plans (GHPs) for services provided to the following groups of Medicare beneficiaries:

- The "working aged."
- People with permanent kidney failure.
- Certain disabled people.

As used in this booklet, a GHP is a plan (including a self-insured plan) that:

- Provides health care—either directly or indirectly through insurance or otherwise—to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, and
- Is contributed to or sponsored by an employer or employee organization.

A GHP includes plans where employees pay all the costs.

The term *plan* includes insurance plans, prepaid arrangements, self-insured plans, plans of governmental entities (Federal, State and local), and employee organization plans, including health and welfare fund plans. A plan can be any arrangement between one or more parties for the provision of health care. The arrangements may be oral or written.

WORKING AGED

The "working aged" are employed people aged 65 or over, and people aged 65 or over with employed spouses of any age, who have GHP coverage because of their or their spouse's current employment.

Medicare is secondary payer to GHPs for the "working aged" where **either**:

- A single employer of 20 or more employees is the sponsor or contributor or an employee organization associated with that employer is the sponsor or contributor, **or**
- Two or more employers or employee organizations are sponsors or contributors, and at least one of the employers has 20 or more employees.

If a single employer with fewer than 20 employees sponsors or contributes to a plan, Medicare is the primary payer for all working aged people enrolled in the plan. Also, if an employee organization, such as a union, is associated only with an employer of fewer than 20 employees and sponsors or contributes to a plan, Medicare is the primary payer for all working aged people enrolled in the plan.

The "20 or More Employees" Threshold

The "20 or more employees" threshold is met when an employer has 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. The 20 calendar weeks do not have to be consecutive. The requirements of the Medicare Secondary Payer law are based on **the number of employees**, not the number of people covered under the plan.

Group health plans can assure correct application of the "20 or more employees" rule by taking the following steps.

- At the beginning of a calendar year, employers should examine their records to determine whether they had 20 or more employees for each working day in each of 20 or more calendar weeks during the preceding calendar year. If so, the threshold has been met, and Medicare is secondary payer for working aged people covered by the group health plan for the entire calendar year that has just begun. Once employers have met the requirement in a particular year, they must provide primary coverage for the remainder of the year and throughout the following year.
- If employers have not satisfied the threshold during the previous calendar year, it is still possible that they will meet it at some point during the new calendar year. Once employers reach the threshold, Medicare becomes secondary payer from that point on through the remainder of that year and throughout the next year. Medicare does not become secondary payer retroactively for the part of the year before the threshold is reached.

Multiple Employer and Multi-employer Plans

The MSP for the working aged requirements apply both to multiple employer plans and to multi-employer plans. A multiple employer plan is a plan sponsored by

more than one employer. A multi-employer plan is a plan jointly sponsored by employers and unions under the Taft-Hartley Law. (Under multi-employer plans, an employer typically pays a premium, based on the hours that a union employee works, into a special health and welfare fund which administers benefits.)

For GHPs with more than one sponsor or contributor, there are three possibilities:

- Where all of the employers have fewer than 20 employees, Medicare is primary payer for all working aged people enrolled in the plan because the plan is not subject to the MSP provisions.

- Where all of the employers have 20 or more employees, Medicare is secondary payer for all working aged people enrolled in the plan.

- Where at least one of the employers has 20 or more employees, even if some have fewer than 20, Medicare is secondary payer for all working aged people enrolled in the plan. There is one exception: a GHP may exempt those working aged people enrolled through an employer with fewer than 20 employees. In that case, Medicare would become primary payer for specifically identified working aged people enrolled through an employer with fewer than 20 employees. The GHP must be able to document its decision to exempt such people. The plan may then offer those people coverage that supplements Medicare.

Employers must follow the Internal Revenue System aggregation rules to determine whether the 20-or-more employee threshold is met. (See 26 U.S.C. Sections 52(a), 52(b), 414(m) and 414(n)(2).)

PEOPLE WITH PERMANENT KIDNEY FAILURE

Medicare is secondary payer to GHPs for 18 months for beneficiaries who have Medicare because of permanent kidney failure. This requirement applies both to those with permanent kidney failure who have their own coverage under a GHP **and** to those covered under a GHP as dependents.

GHP coverage is primary to Medicare during the period described below. This rule applies without regard to the number of employees and without regard to the enrollee's employment status (for example, full or part time, or retired).

The period during which the GHP is primary begins with the earlier of:

- The first month of the enrollee's entitlement to Medicare Part A on the basis of permanent kidney failure

- The first month in which the enrollee would have been entitled to Medicare Part A, if he or she had filed an application for Medicare on the basis of permanent kidney failure.

As provided by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993; enacted August 10, 1993), the 18-month period during which the plan is primary applies to all beneficiaries with permanent kidney failure, regardless of whether they may also be entitled to Medicare because of age or disability. This means that plan coverage of aged and disabled people based on retirement is now subject to the 18-month coordination period. Before OBRA 93, the 18-month coordination period was in effect (including retirement coverage) only where the person was eligible for or entitled to Medicare **solely** because of permanent kidney failure.

The HCFA publication *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration or from HCFA.

DISABLED PEOPLE

Medicare is secondary payer for people under age 65 who have Medicare because of disability (that is, they have received 24 months of Social Security disability benefits) and who are covered under a large group health plan (LGHP) because of their current employment or the current employment of a family member.

An LGHP is a plan sponsored or contributed to by an employer or employee organization (such as a union). The plan:

- Provides health care to employees, former employees, the employer, business associates of the employer or their families, and

- Covers employees of at least one employer with 100 or more employees.

The term LGHP includes plans in which employees pay all the costs.

A group health plan that covers employees of at least one employer that had 100 or more employees on 50 percent or more of its business days during the preceding calendar year meets the definition of an LGHP. An LGHP which is a multiple or multi-employer plan may **not** exempt people enrolled through an employer with fewer than 100 employees from the MSP disabled provision. Medicare is the secondary payer for **all** disabled people enrolled in an LGHP where coverage is based on the current employment of the disabled person or the current employment of a member of his or her family.

Employers must follow the Internal Revenue System aggregation rules to determine whether the 100-or-more employee threshold is met. (See 26 U.S.C. Sections 52(a), 52(b), 414(m) and 414(n)(2).)

EMPLOYER RESPONSIBILITIES UNDER MSP

Employers have a number of important responsibilities under the MSP law:

- To assure that their plans identify those people to whom the MSP requirements apply;
- To assure that their plans provide for proper primary payments when the law makes Medicare the secondary payer;
- To assure that their plans do not discriminate against employees and employees' spouses aged 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries for whom Medicare is secondary payer; and,
- To complete data match reports on identified employees timely and accurately.

When Congress passed the original MSP for the working aged legislation, it indicated its intent to prohibit employers from offering health insurance plans or options designed to induce employees to reject coverage under the employer plan. In 1990, Congress clarified its position that this prohibition applied to all group health plans which cover people to whom the MSP requirements apply. Employers are responsible for assuring that their plans do not include prohibited inducements for Medicare beneficiaries to decline or to terminate coverage.

Working Aged

If you are an employer with 20 or more employees, your GHP must not discriminate against employees aged 65 or over, or employees' spouses aged 65 or over, whether or not they have Medicare. Also, the benefits offered to these people under your plan must not differ in any way from the benefits offered to people who do not have Medicare. Your GHP must be primary payer for those benefits in MSP situations, and must not take into account working aged people's entitlement to Medicare. GHPs must not, for example:

- Fail to make primary payment, or make a smaller payment, on behalf of someone for whom Medicare is secondary payer;
- Reduce or terminate coverage of employees and employees' spouses aged 65 or over, either (1) because they have become entitled to Medicare, or (2) because they have reached age 65;
- Reduce or terminate coverage for aged 65 or over employees and spouses on a different basis from younger employees and spouses;
- Refuse to allow employees and employees' spouses aged 65 or over to enroll, or to reenroll, on the same basis as younger employees and spouses;
- Impose limitations, exclusions, or reductions in benefits on those aged 65 or over that are not applicable to younger people who are enrolled in the plan; or
- Impose higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness conditions for those aged 65 or over than are applicable to those under 65 who are enrolled in the plan.

You must inform working aged employees and their spouses who are entitled to Medicare that they may reject coverage under your plan and choose Medicare as their primary payer. There is no official Medicare election form. However, if you are audited by HCFA, you must be able to prove that the employee or spouse was properly informed and rejected coverage under your plan. You should also ensure that the employee or spouse understands that **if the employee or spouse rejects coverage under your group health plan, you may not offer, subsidize, sponsor or arrange for a plan intended to supplement Medicare's benefits**. Your plan may, however, offer the employee or spouse coverage for items and services for which Medicare provides no benefits (for example, prescription drugs and eyeglasses).

Beneficiaries who reject your group health plan may purchase Medicare supplemental (Medigap) coverage from a source other than you. **You may not purchase, subsidize, sponsor or arrange for an individual supplemental policy for the employee or spouse.**

People With Permanent Kidney Failure

For people who have Medicare because of permanent kidney failure, during the 18 months in which a GHP must pay first:

> The GHP must be primary payer for them and not take into account their entitlement to Medicare based on permanent kidney failure. The GHP must not, for example, fail to make primary payment or make a smaller payment on behalf of someone for whom Medicare is secondary payer. In addition, the GHP must not discriminate against them because they have permanent kidney failure. The benefits provided must not differ in any way from the benefits provided to people who do not have permanent kidney failure. This nondiscrimination requirement applies both during and after the period when Medicare is secondary payer, and whether or not a person is entitled to Medicare.

For all people with permanent kidney failure, with or without Medicare, during the 18 month period, the plan may not, for example:

- Refuse to allow a person with permanent kidney failure to enroll, or to reenroll, in the plan, on the same basis as people who do not have permanent kidney failure,
- Impose limits on benefits, reduce benefits, or impose exclusions on enrollees who have permanent kidney failure that are not applicable to enrollees who do not have permanent kidney failure, or
- Impose higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness conditions than are applicable to those who do not have permanent kidney failure.

However, this "nondifferentiation" requirement does not prohibit GHPs from taking into account Medicare eligibility or entitlement based on permanent kidney failure after the 18 month period expires.

People With Disability

An LGHP must not discriminate against disabled Medicare beneficiaries for whom Medicare is secondary payer. This means that it must not treat these people differently from other enrollees because they are disabled and have Medicare.

For example, with respect to these disabled Medicare beneficiaries, an LGHP must not:

- Fail to make primary payment, or make a smaller payment on behalf of someone for whom Medicare is secondary payer,
- Terminate coverage on the basis of entitlement to Medicare,
- Provide for different benefits, or a different level of benefits, on the basis of entitlement to Medicare, or
- Charge a higher premium than it charges to other enrollees in the plan.

Employers must offer disabled Medicare beneficiaries the opportunity to reject the LGHP's coverage. In that case, Medicare becomes their primary payer, and the employer must not offer them, sponsor, subsidize or arrange for supplemental coverage, exc for items and services not covered by Medicare (for example, prescription d and eyeglasses). However, as with the working aged, beneficiaries w eject the LGHP may purchase Medicare supplemental coverage (Medigap) fro a source other than the employer, so long as the employer does not purchase, sponsor, subsidize or arrange for the coverage.

MAKING MSP WORK

The organizations under contract with HCFA to pay Medicare claims (Medicare carriers and intermediaries) are responsible to deny claims for primary benefits when Medicare is secondary payer. These contractors are also responsible for informing providers, employers, insurers and beneficiaries about MSP and how it works. Staff members from Medicare contractors give talks on MSP to hospital groups, insurance associations, beneficiary advocacy organizations and others. A representative of a Medicare contractor in your area would be happy to talk to your organization about MSP or any other Medicare issue you would like to discuss.

Contractors collect information before paying Medicare claims to avoid costly and time-consuming recovery of Medicare mistaken payments. For example, they may call or write to employers, insurers, claims administrators, or hospitals. When a

contractor has reason to believe that a claim should be paid first by another payer, it generally withholds payment while it investigates whether Medicare is secondary.

Sometimes, after a Medicare claim is paid, a Medicare contractor gets new information that indicates Medicare made a primary payment by mistake. Based on this new information, the contractor seeks to recover the mistaken Medicare payment.

Contractors will send initial demand letters for repayment directly to an employer only when a Group Health Plan is self-insured and self-administered by the employer. In most situations, the initial request for repayment will be made to the plan' s insurer, underwriter, third party administrator, HMO, or other entity responsible for processing claims.

If the party the contractor determines responsible to issue the primary payment disputes that determination and does not refund the money, the contractor sends the demand letter to the employer because the employer is responsible for the plan. If an employer receives a demand letter, the employer should contact the entity required or responsible to pay under the plan to resolve the situation.

If HCFA does not recover its payment, the agency may refer the case to the Department of Justice for legal action. The law authorizes the Federal government to collect double damages from any party which is required to make primary payment but which fails to do so.

HCFA may also report GHPs or LGHPs that refuse to follow MSP rules or refuse to reimburse Medicare conditional payments—these are called "nonconforming group health plans"—to the Internal Revenue Service (IRS). IRS is required to impose a tax on the employers or employee organizations that contribute to those nonconforming plans. The tax is equal to 25 percent of all the contributions the employer or employee organization made to all group health plans during the year. This tax provision is found in Section 5000 of the Internal Revenue Code (26 U.S.C. Section 5000).

HCFA may also send the case to the IRS under the Tax Refund Offset Program. Any outstanding amount will be collected from the tax refund account of the employer.

EMPLOYER REQUIREMENTS UNDER THE MSP DATA MATCH PROVISIONS

Data Match

In 1989, Congress enacted a law to provide HCFA with better information about Medicare beneficiaries' health insurance. The law authorizes the IRS, the SSA, and HCFA to share certain information that each agency has about whether Medicare beneficiaries or their spouses are working. The process for sharing this information is called the **Data Match**. The purpose of the Data Match is to identify situations where other insurance may be primary to Medicare.

Employer Contact

The Data Match is identifying employers of beneficiaries for whom employer coverage, if available, is likely to be primary to Medicare. The law requires that HCFA contact these employers to confirm coverage information. A Medicare contractor designated by HCFA began contacting employers in late 1990 and will continue to do so until 1998.

Your Responsibilities As An Employer

The HCFA contractor is providing each employer with information from the Data Match, including the names and social security numbers of employees, and spouses of employees, when either or both have Medicare. HCFA is asking for information about employer health coverage that each of these people had, such as:

- Worker only coverage
- Worker and spouse coverage
- Names and addresses of the health plans
- Periods of employment
- Type of health coverage
- Numbers of people employed.

The law requires each employer to respond within 30 days to the HCFA contractor's request for information.

Employers with multiple reporting sites can arrange to have all requests sent to one central location by calling the data match contractor using the toll free number listed below. Employers can also arrange with the data match contractor to report through an electronic bulletin board system.

Employer Penalties

You may be assessed a civil monetary penalty of $1000 for **each** worker for which an inquiry concerning health coverage was made, if:

- You do not respond within 30 days, or
- You knowingly give inaccurate information.

NOTE: The assessment of a civil monetary penalty will not relieve you of the requirement to provide this information.

Where to Obtain Assistance

If you have questions about your responsibilities under the data match or you want to request a 30-day extension beyond the allotted 30 days to complete the data match questionnaire, call this toll-free number:

1-800-999-1118

Any request for an extension beyond the 60 days (the original 30 days and one 30-day extension) for filing will require you to detail the reasons in a letter written to:

Health Care Financing Administration
IRS/SSA/HCFA Data Match
c/o Data Match Contractor
P.O. Box 1811
New York, NY 10023-1479

If you have questions about Medicare Secondary Payer requirements, write to:

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207-5187

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